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DATE NOTICE SENT TO ALL PARTIES: Oct/26/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: MRI of the lumbar spine

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Board Certified Internal Medicine

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is this reviewer's opinion that medical necessity for the request of MRI of the lumbar spine has not been established

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who was injured on XX/XX/XX when she fell injuring her low back. Prior treatment has included physical therapy, injections, and medications. From the prior determination letters it appears that MRI studies were completed on xxxx; however, these were not available for review. There was a radiograph study of the lumbar spine from xxxx which found a mild amount of thoracolumbar dextroscoliosis with preserved disc space height. No significant spondylolisthesis or other findings were noted. The patient's xxxx evaluation noted continuing low back pain. The patient's physical examination found no neurological deficits evident. The requested MRI study of the lumbar spine was denied on xxxxx as prior MRI studies had not found evidence of significant pathology and there was no evidence of neurological deficit. The request was again denied on xxxxx as there was no significant changes in symptoms or evidence of significant pathology.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for continuing low back complaints despite conservative treatment. Prior MRI studies which were not available for review were reported to show no significant pathology. The most recent clinical assessment did not identify any focal neurological deficits that were either severe or progressive in nature. Given the lack of evidence regarding any new or progressively worsening neurological findings, repeat MRI studies would not be supported per guideline recommendations. As such it is this reviewer's opinion that medical necessity for the request of MRI of the lumbar spine has not been established and the prior denials remain upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)